Your Health Limited

Redmount Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Redmount Residential Care Home is a residential care home providing personal care for up to 36 people aged 65 and over. At the time of the inspection there were 21 people living at the service.

People's experience of using this service and what we found
The provider had failed to have sufficient oversight of the service to ensure people received safe and consistently well-managed care and support. This impacted on the quality of the health, safety and care provided to people. Concerns identified at the previous inspections had not been fully addressed. Repeated concerns had been noted at this inspection.

People were placed at risk of unsafe care as their care needs and associated risks had not been routinely assessed, updated and monitored. Recognised risk assessment tools and monitoring records in place were not always accurately completed.

People at risk of losing weight were not always managed safely. Systems in place to monitor people's weight had failed to ensure timely or appropriate action was taken when people had lost weight.

People who were at risk of skin damage did not always receive effective pressure area care. Repositioning schedules were not in place for people who needed support to move in bed and records did not demonstrate that people had their prescribed creams applied to protect their skin.

There were poor infection prevention and control measures in place at Redmount Residential Care Home. Staff did not always use PPE effectively and safely and in accordance with current government guidelines.

People were not always protected from risks associated with their environment. The services fire risk assessment identified several actions which needed to be completed were outstanding from the previous fire risk assessment dated September 2020.

Medicines were not always managed safely. People did not get always get their medicines as prescribed for them or when they needed them which put their health at increased risk.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staffing was not always planned or deployed in a way that met people's specific health care needs. People who required support and assistance were being left for long periods of time as staff were busy in other parts of the service. We have made a recommendation about this.

A lack of direction and leadership provided to staff resulted in areas where the culture of the service needed to be improved. Although we observed many positive interactions between people and staff during the inspection, the language some staff used when talking with people, was disrespectful and did not promote their dignity.

Although people told us that they enjoyed the food provided at the home, we observed people did not receive a person-centred dining experience. Records did not accurately record what people had eaten or drank and they were not always given what they had originally been offered or requested eat.

People were supported by staff who had received training to help ensure they could meet people's needs safely and effectively. However, staff induction specific to the service, had not been fully completed. We made a recommendation about this.

People felt safe and received care from staff who had been appropriately recruited and trained to recognise signs of abuse or risk and understood what to do and who to contact if they suspected people were at risk.

Feedback from relatives was mainly positive and they felt staff were kind and caring and doing their very best for people living at the service.

Accidents and incidents were recorded and reviewed by the manager and provider to identify any learning which may help to prevent a reoccurrence.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (29 July 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

The service remains rated requires improvement. This is the third consecutive inspection where the service has been rated requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about medicines management, manual handling, staffing and poor-quality care. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk management, person centred care, dignity and privacy, choice and consent, and good governance at this inspection.

We also made two recommendations in relation to staffing arrangements and the deployment of staff and ensuring that all staff working at the service have completed an induction.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Redmount Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors. A third inspector from the medicines team attended on 28 March 2022. An Expert by Experience also carried out telephone calls to some relatives on 24 March 2022. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type
Redmount Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The manager registered with the Care Quality Commission had left the service in January 2022 but had not deregistered. The provider was legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced on the first day.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service, including the safeguarding team. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We looked at the response from the provider to the concerns we had received about the service. We used all of this information to plan our inspection. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service and two relatives' about their experience of the care provided. We spoke with members of staff including the nominated individual, operations manager, quality manager, deputy manager, care workers, kitchen staff and administration assistant. We also spoke with eight relatives on the telephone. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, handover and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and had failed to ensure people were protected by safe infection control practices. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvement had not been made at this inspection and the provider was still in breach of regulations.

● People were placed at risk of unsafe care as their care needs and associated risks had not been routinely assessed, updated and monitored. In some people's records information was historic and had not been updated. For example, recognised risk assessment tools in place such as Waterlow and Malnutrition Universal Screening Tool (MUST), were not always accurately completed, which meant the provider could not be assured they would highlight deterioration in people's physical health and wellbeing.
● People at risk of losing weight were not always managed safely. Whilst there were systems in place to monitor people's weight, the provider had failed to ensure timely or appropriate action was taken when people had lost weight. For example, weight monitoring charts for one person showed since October 2021 they had lost 8kg. The provider's action plan from January 2022 advised a fortified diet, food and fluid monitoring and to be weighed weekly. However, records show the person's weight was not monitored weekly and kitchen staff were not aware this person required a fortified menu. By not acting appropriately to weight loss in a timely way and ensuring effective action, the provider placed people at risk of harm.
● Where people required their fluids to be monitored, recording charts were not always completed or completed in sufficient detail to provide assurances that people had received adequate hydration. This placed people at risk of harm due to dehydration. For example, one person's fluid intake chart recorded they had received less than 600mls of fluid on eight days between 21 December 2021 and 17 March 2022.
● We were told at the time of the inspection, no one at the service had a pressure ulcer or skin damage. However, people at risk of skin damage through immobility, incontinence and/or poor health, could be exposed to increased risk as they did not always receive effective pressure area care. For example, repositioning schedules were not in place for people who were not able to move themselves in bed and records did not demonstrate that people had their prescribed creams applied to protect their skin from damage.
● Best practice guidance was not always followed in relation to infection control. Staff were observed either

not wearing a mask, wearing their mask hanging from their ear or wearing their mask below their noses whilst working in close proximity with people. Two visitors told us they frequently observed staff not wearing their masks or PPE correctly when they visited people living at the service. This meant that PPE was not fully effective and there was a risk infection could be more transmissible.

● The provider had not always ensured staff follow best practice guidance in relation to hygiene practices at the service. During the inspection we observed a staff member had discarded a used incontinence pad and used cleaning wipes on the floor of one person's bedroom.

● We were not assured that the provider was meeting shielding and social distancing rules. The service had three communal areas for people to use. However, only one area was used during the inspection and people were not being supported to maintain a social distance whilst in the communal lounge. There was no signage in place to remind people and staff to maintain a social distance.

● People were not always protected from risks associated with their environment. During a tour of the service we found cleaning products had been left unattended and a hot water pipe on the second floor had not been fully lagged. The hair salon did not contain any fire detection. This meant people living at the service had potentially placed at risk of avoidable harm. We discussed what we found with the nominated individual and senior staff who took action to address our concerns. We have shared our concerns with Devon and Somerset Fire and Rescue Service.

● We reviewed the home's fire safety precautions. Records showed a fire risk assessment had been completed in February 2022, which identified several actions which needed to be completed within a specified time frame. We noted a number of these actions were outstanding from the previous fire risk assessment dated September 2020. For example, the replacement of intumescent seal around doors.

● Following a visit to the service in February 2022, Devon and Somerset Fire and Rescue Service had advised the provider to have the fire alarm panel inspected by a competent person. At the time of this inspection this had not taken place.

● We discussed what we found with the provider who assured us these would be addressed.

Whilst we found no evidence that people had been harmed. The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or managed. This placed people at risk of harm and was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Fire safety systems were serviced regularly.

● Premises, equipment and safety checks were undertaken in relation to the environment and the maintenance and safety of equipment.

● We were assured that the provider was preventing visitors from catching and spreading infections. A relative told us, "I visit once a week at weekends, and I can now go into her room and I wear a mask."

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

● We found the service's approach to visiting aligned with government guidance. People were enabled to have visitors and no restrictions were placed on relative's visits to the service.

Using medicines safely

At our last inspection the provider had failed to ensure people received their medicines safely or as prescribed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

● People were supported to take their medicines by staff who had received medicines training. However, we saw that errors occurred when staff that did not usually work in the home, gave medicines. For example, on 26 March 2022 we were told that a staff member from the head office had to administer medicines due to staff shortages. Several errors, such as missed doses had been identified at the time by the provider. However, we found recording errors where the medicines administration record (MAR) had not been signed, had not been identified at the time by the provider.
● Systems and processes in place to carry over ongoing medicines at the beginning of a new recording month, was not robust. On the day of the inspection, new MARs were in place to be used at the start of the monthly cycle. We found medicines for two people prescribed short courses of antibiotics, had not been carried over as it should. This had not been identified by staff and meant the morning and lunchtime doses had not been given.
● Although it was clear from MAR charts how people liked to take their medicines, care plans did not contain up to date and complete information on people's current prescribed medicines. This meant staff may not be aware of important information about their medicines which would put them at risk.
● Although written guidance was in place to help staff decide when to administer a 'when required' medicine. One staff member, responsible for administering medicines, told us they would not feel confident to administer a medicine prescribed to be used infrequently for chest pain as they had not had sufficient support and training.
● Controlled drugs were stored and given to people appropriately. However, the entries in the register were not always accurate. The register itself was damaged meaning it did not meet the legal requirements.

Not having safe processes to manage people's medicines is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were available to people, in date and stored securely.
● Where necessary, medicines were dated when they were opened, for example eye drops, and safely disposed of when expired.
● Relatives did not have any concerns about people receiving their medicines as prescribed for them. One relative told us, "[Name] is on medication and I had a big issue with her taking her medication before she went in there, but here at Redmount, no problem they make sure she has taken it."

Staffing and recruitment
● The provider told us staff were employed in sufficient numbers to meet people's changing needs and these were regularly reviewed. The provider used a dependency tool to identify out how many staff were needed to meet people's needs safely. Due to information technology challenges, this information was not available at the time of the inspection. However, we found staff were not always planned or deployed in a way that met people's specific health care needs. For example, during meals times we saw people who required support and assistance to eat and drink were being left for long periods of time as staff were busy in other parts of the service.

We recommend the service reviews staffing arrangements and the deployment of staff to ensure people receive the care, support and supervision they require to meet their needs in a timely manner.

● People were protected by safe recruitment processes.
● Systems were in place to ensure staff were recruited safely and records confirmed a range of checks

including references, disclosure and barring checks (DBS) had been requested and obtained prior to new staff commencing work in the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● Despite our concerns, people told us they felt safe and well cared for. One relative told us, "Yes she is well, secure and safe. The staff understand her needs and treat her well and are friendly with her." Another relative commented, "She is safe because she says it feels like home."

● The provider had reported safeguarding concerns and worked with relevant agencies in line with local safeguarding protocols. Records of referrals, their progress, investigation and outcome were monitored, with records kept.

● Staff had been trained in safeguarding procedures and knew what action to take to protect people from harm and abuse. This included knowledge in who to report concerns to, both internally and to external agencies.

Learning lessons when things go wrong

● Accidents and incidents were recorded and reviewed by the manager to identify any learning which may help to prevent a reoccurrence. This information was also shared with the providers central office team for further review.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● The timings of meals provided by the service was not person centred but was scheduled to the availability of kitchen staff. Staff told us and we saw that people received their main meal between 12.30 and 13.30. Their next meal was served between 16.00 and 16.30 before kitchen staff went off duty for the day. This meant that people received their evening meal between 2 – 3 hours after their main meal. Staff told us and we saw from records, that some people often refused their meal in the afternoon as they were not hungry, or they would eat less.

● Whilst we saw snacks were available and staff offered snacks to people, these were generally high calorie snacks that were not very nutritious and not a substitute for a healthy meal. One person told us in the evening when they were hungry and thirsty, they did not like to bother staff as they were too busy so they would go without. They said, "I feel like something's missing in the evening like a food trolley."

● Our mealtime observations did not demonstrate people received a person-centred dining experience. Despite the service having dining room areas, on the first two days of the inspection, people were not asked if they wished to be seated in the dining room for their meal. Meals were served to people at their chairs in the lounge.

● People did not always receive the support they needed or required. For example, one person who was sat in a chair with their feet up, was struggling to reach their meal. We observed staff walked past this person on several occasions and did not notice they were struggling.

● We observed thirteen people in the lounge and dining area, some of whom required support and/or encouragement to eat their meal. During our observations of that lunchtime period, fifty percent of the time there were no staff present to support people.

● Records did not accurately record what people had eaten or drank. For example, records for one person stated they had eaten all their meal when we observed that they had not. While records for another person stated they had not eaten their lunch at all. We observed this had been offered and declined and an alternative meal offered, which they ate.

● People were not always given what they had been offered or requested to eat. For example, one person was offered salad by the new manager who in turn requested this from the chef. We observed this person was served braised steak and mashed potatoes.

● People did not always receive food and drink in line with their assessed needs. For example, one person's care plan stated they had lost weight and they should have a fortified diet and calorific snacks. However, when we spoke with kitchen staff, they were not aware of this.

People were not provided with individualised care that met their needs. This was a breach of regulation 9 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People told us that they enjoyed the food provided at the home. One person said, "It's my favourite today." We received mixed feedback about the food provision from the relatives we spoke with. Some told us their relative enjoyed the food. which had recently improved at the service, and they had plenty to eat, but two relatives told us they felt their relative did not get enough to eat. Comments included, "There is enough food, and he says the chef is tip top", "Mum has said she is starving. We take her in a sandwich" and "She loves the food and there are always plenty of drinks."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People did not always have their capacity assessed when necessary and best interests meetings had not taken place to ensure decisions made were appropriate and least restrictive. For example, a mental capacity assessment and best interests decision had not taken place for one person that required an alarm sensor mat to alert staff when they got out of bed so that staff could support them to walk around safely.
● Where decisions had been made and documented, these had not always been made with people legally authorised to do so. For example, one person lacked capacity to consent to their flu vaccine. A mental capacity assessment had not taken place and consent for the flu vaccine had been gained from their relative who did not have power of attorney or the legal authority to do so.

We found no evidence that people had been harmed. However, systems were not robust enough to demonstrate decisions were being made with the relevant people involved, made appropriately and the least restrictive option. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were aware of their duties and responsibilities in relation to the MCA. For example, staff understood who they supported that lacked capacity and told us they always asked for people's consent before commencing any personal care tasks.
● Relatives told us they observed staff giving choices to people. One relative told us, "She has the option to go downstairs and can make her own choices."

Staff support: induction, training, skills and experience
● The deputy manager told us that all staff completed an induction and did not work unsupervised until

they had been assessed as competent to do so. We reviewed staff files and found induction paperwork had not been fully completed.
● Due to recruitment pressures the service had used agency staff to cover some shifts. Whilst there was a clear system in place to obtain details of agency staffs' qualifications and provide a service specific induction. We found inductions had not always taken place.

We recommend the registered manager reviews the systems in place to ensure that all staff working at the service have completed an induction specific to the service and the people they support.

● People were supported by staff who had received training to help ensure they could meet people's needs safely and effectively. The services training matrix showed staff had received training in a variety of subjects such as safeguarding, infection control, moving and handling, health and safety and medicines. However, concerns we found as described in the safe section of this report, suggests that staff learning from training courses were not embedded or put into practice at the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of need were not consistently carried out in a timely way to ensure everyone who lived at Redmount Residential Care Home had relevant and up to date assessments and care plans, which accurately reflected their health and social care needs. This meant people were at risk of not having their needs effectively met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with healthcare professionals to ensure people's healthcare needs were met, such as, GPs and community-based health professionals to manage people's ongoing health conditions.
● Relatives told us about regular appointments people had to help with their health and wellbeing including visits by opticians and the chiropodist.

Adapting service, design, decoration to meet people's needs
● The environment was accessible to people using the service and there were communal areas for people to enjoy. However, we saw that one area of the communal lounge and a corridor on the first floor was very cluttered with equipment.
● Improvements were needed to outside enclosed garden space to make it a more safe, suitable and stimulating outside space for people living with dementia.
● Some carpets in the service smelled of urine, were showing signs of wear and tear and were stained. The management team told us these were scheduled to be replaced.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

During our two previous inspections the provider had failed to ensure that management oversight of the service was robust, and risk to people's health and welfare was not effectively managed to protect people from harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

- The service had not had a registered manager in post since January 2022. This meant the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service was run, was the responsibility of the registered provider. In the absence of a registered manager the provider had recruited two interim managers to support and lead the service. This leadership support had not been effective in promptly identifying the areas requiring improvement we identified during this inspection.
- Since the last inspection in May 2021, the provider had failed to have sufficient oversight of the service to ensure people received safe and consistently well-managed care and support. Systems operated by the provider to assure themselves of the quality of care provided had failed to identify concerns and shortfalls we found during this inspection.
- Fire safety procedures at the home were not safe. The provider had not addressed all fire safety actions identified from the previous fire risk assessment dated September 2020. This put people at risk of harm.
- The provider's quality and monitoring systems had failed to ensure that legislation was complied with. For example, mental capacity assessments and best interests decisions were not always completed in line with of the requirements of the Mental Capacity Act 2005.
- Infection control was not well managed in the service to ensure people were not at risk from infection. The provider had not ensured staff wore their PPE as required by government guidance.
- Quality monitoring systems had failed to ensure all people who lived at the service had an up to date and complete care plan and risk assessments to fully meet their needs. Oversight of monitoring charts had not been sufficient to ensure people received appropriate care. Records were not always completed accurately to manage and ensure that people's on-going needs were met. There were gaps in records where staff should have documented the care they had provided. This put people at risk of harm.
- The provider's quality assurance processes had failed to identify that appropriate and/or timely action

had not taken place when people had lost weight, which meant people were at risk of further weight loss.
● Systems and processes in place had failed to ensure action was taken when people were identified at risk of skin damage. Poor skin care management meant that people were at risk of harm due to sore and painful skin that was not managed or treated properly.
● Quality auditing systems and processes in place had not identified errors in medicines management. People did not always receive their medicines or creams prescribed for them. This put people at risk of harm from medicines errors and omissions.
● The provider's oversight had failed to identify that people were not always experiencing person-centred care.
● Processes in place had failed to identify that not all staff, including agency staff, had received an induction to the service.
● The provider had not acted on feedback in a timely manner. Concerns identified at the previous two inspections had not been fully addressed. Repeated concerns had been noted at this inspection.

The lack of robust governance systems meant people were at risk of receiving unsafe care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider acknowledged their quality oversight needed to be improved for them to identify the issues we identified. They told us that with the new manager, who started at the service during the inspection, they expected to be able to make the improvements necessary.
● Notifications of significant events had been submitted to the commission, as required.
● Despite our findings, relatives were positive about the management at the service. One relative told us, "It is well run and organised and with the resources they have they do a splendid job." Another said, "It is better run now, and I can talk to people there now. it was awful before. I need to give them time to make improvements."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The absence of strong consistent leadership and provider oversight had resulted in a lack of direction and leadership provided to staff. This resulted in areas where the culture of the service needed to be improved.
● Although we observed many positive interactions between people and staff during the inspection, the language some staff used when talking with people, was disrespectful, did not promote people's human rights or show they were valued as equal partners in their care. For example, we saw one person was told to chill out and have a seat. We observed another staff member laughing with another member of staff about someone's actions, which was unprofessional and inappropriate.
● We overheard staff talking about one person's toileting needs in the doorway of the lounge were people sat and could clearly hear what was being said and about whom.

The provider had failed to ensure that people were treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were knowledgeable about people who used the service and were able to describe people's likes and dislikes, as well as how they preferred their care to be delivered.
● People's relatives felt staff were kind and caring. One relative said, "Mum is being looked after and I am happy with the care."

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
● We received mixed feedback from people's relatives about the communication and support they received from the management team at Redmount. Comments we received included, "Contact is not always easy to get through, but better now as there is somebody on reception", "They do not ask my views and I am not aware of any meetings. I get no e-mails or newsletters" and "I get updated when I ring every week. They do ask my views when I ring."
● The provider had sought feedback and had sent out surveys to people and relatives to identify areas for improvement.
● Staff told us they had regular handover and team meetings to share important information about people and to discuss any ideas they may have to make improvements to the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was aware of their responsibilities under the duty of candour, which is a regulation all providers must adhere to.
● The senior management team and staff at the service were open and honest during the inspection and told us they were committed to make improvements.

Working in partnership with others
● The provider worked alongside other organisations to meet people's care needs. This included occupational therapists, district nurses, GPs, and other healthcare providers.
● At the time of the inspection the service was being supported by the local authority whole service safeguarding process and local authority quality improvement team to make the necessary improvements at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not provided with individualised care that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with dignity and respect. Staff did not always interact with people in a caring or compassionate manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were not robust enough to demonstrate decisions were being made with the relevant people involved, made appropriately and the least restrictive option.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or managed. The provider did not always ensure the safe management and administration of medicines.

The enforcement action we took:

On 9th June 2022 under Section 28(3) of the Health and Social Care Act 2008 we issued a notice of decision to impose a condition on the providers registration for the regulated activities of accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality monitoring system was not being operated effectively to ensure people's health and safety. Accurate records were not always maintained.

The enforcement action we took:

On 9th June 2022 under Section 28(3) of the Health and Social Care Act 2008 we issued a notice of decision to impose a condition on the providers registration for the regulated activities of accommodation for persons who require nursing or personal care.